Initial History Questionnaire for Pediatric Patients

Name____
Address____
____
Phone number ____
Date of birth______________________________ Current age ________________
Sex: M F
Form completed by ____
Date completed ____

Household

Please list all those living in the child's home.

Name	Relationship to Child	Birth date	Health Problems

Are there siblings not listed? If so, please list their names, ages, and whei they live. ____
____

What is the child's living situation if not with both biological parents?

Lives with adoptive parents Joint custody Single custody

Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

____
____

Birth History *Don't know birth history*

*Birth weight*____

*Was the baby born at term?*________________________*weeks*

Were there any prenatal or neonatal complications? Yes No

Explain ____

Was a NICU stay required? Yes No Explain ________________________

During pregnancy, did mother:

Use tobacco? Yes No Drink alcohol? Yes No

Use drugs or medication? Yes No Used prenatal vitamins Yes No

Was the delivery Vaginal Cearean If cesarean, why? ________________________
____
____

Was initial feeding Formula or Breast milk
How long breastfed? ______________________

Did your baby go home with mother from the hospital?
☐ *Yes* ☐ *No Explain* ____

General *DK = don't know*

Do you consider your child to be in good health? Yes No

*Does your child have any serious illnesses or medical conditions? Yes No DK Explain*___________________________________

Has your child had any surgery? Yes No DK Explain ___________________________________

Has your child ever been hospitalized? Yes No DK Explain ___________________________________

Is your child allergic to medicine or drugs? Yes No DK Explain ___________________________________
Do you feel your family has enough to eat? Yes No DK Explain ___________________________________

Biological Family History *DK = don't know*

Have any family members had the following?

*Childhood hearing loss Yes No DK Who*______________________*Comments* ________________________
*Nasal allergies Yes No DK Who*______________________*Comments* ________________________
*Asthma Yes No DK Who*______________________*Comments* ________________________
*Tuberculosis Yes No DK Who*______________________*Comments* ________________________
*Heart disease (before 55 years old) Yes No DK Who*______________________*Comments* ________________________
*High cholesterol/takes medication Yes No DK Who*______________________*Comments* ________________________
*Anemia Yes No DK Who*______________________*Comments* ________________________
*Bleeding disorder Yes No DK Who*______________________*Comments* ________________________
*Dental decay Yes No DK Who*______________________*Comments* ________________________
*Cancer (before 55 years old) Yes No DK Who*______________________*Comments* ________________________
*Liver diease Yes No DK Who*______________________*Comments* ________________________
*Kidney disease Yes No DK Who*______________________*Comments* ________________________

Bed-wetting (after 10 years old)	Yes	No	DK	*Who*__________	*Comments* __________
Obesity	Yes	No	DK	*Who*__________	*Comments* __________
Epilepsy or convulsions	Yes	No	DK	*Who*__________	*Comments* __________
Alcohol abuse	Yes	No	DK	*Who*__________	*Comments* __________
Drug abuse	Yes	No	DK	*Who*__________	*Comments* __________
Mental illness/depression	Yes	No	DK	*Who*__________	*Comments* __________
Developmental disability	Yes	No	DK	*Who*__________	*Comments* __________
Immune problems, HIV, or AIDS	Yes	No	DK	*Who*__________	*Comments* __________
Tobacco use	Yes	No	DK	*Who*__________	*Comments* __________

Additional Family History: ______________________________

Past History *DK = don't know*

Does your child have, or has your child ever had any of the following?

Chickenpox	Yes	No	DK	When
Frequent ear infections/Problems with hearing	Yes	No	DK	Explain
Cancer	Yes	No	DK	Explain
Nasal allergies	Yes	No	DK	Explain
Problems with eyes or vision	Yes	No	DK	Explain
Asthma, bronchitis, bronchiolitis, or pneumonia	Yes	No	DK	Explain
Any heart problem or heart murmur	Yes	No	DK	Explain
Anemia or bleeding problem	Yes	No	DK	Explain
Blood transfusion	Yes	No	DK	Explain ______________________________
HIV	Yes	No	DK	Explain
Organ transplant	Yes	No	DK	Explain
Malignancy/bone marrow transplant	Yes	No	DK	Explain
Chemotherapy	Yes	No	DK	Explain
Frequent abdominal pain	Yes	No	DK	Explain
Constipation requiring doctor visits	Yes	No	DK	Explain
Recurrent urinary tract infections and problems	Yes	No	DK	Explain
Congenital cataracts/retinoblastoma	Yes	No	DK	Explain
Metabolic/Genetic disorders	Yes	No	DK	Explain
Kidney disease or urologic malformations	Yes	No	DK	Explain
Bed-wetting (after 5 years old)	Yes	No	DK	Explain
Sleep problems; snoring	Yes	No	DK	Explain
Chronic or recurrent skin problems (eg, acne,	Yes	No	DK	Explain
Frequent headaches	Yes	No	DK	Explain
Convulsions or other neurologic problems	Yes	No	DK	Explain
Obesity	Yes	No	DK	Explain
Diabetes	Yes	No	DK	Explain
Thyroid or other endocrine problems	Yes	No	DK	Explain
High blood pressure	Yes	No	DK	Explain
History of serious injuries/fractures/concussions	Yes	No	DK	Explain
Tobacco use	Yes	No	DK	Explain
ADHD/anxiety/mood problems/depression	Yes	No	DK	Explain
Developmental delay	Yes	No	DK	Explain ______________________________
Dental decay	Yes	No	DK	Explain ______________________________
History of family violence	Yes	No	DK	Explain ______________________________
Sexually transmitted infections	Yes	No	DK	Explain ______________________________
(For girls) Pregnancy	Yes	No	DK	Explain ______________________________
Has had first period	Yes	No	DK	Age at first period______________________________
(For girls) Problems with her periods	Yes	No	DK	Explain ______________________________

Any other significant problem:______________________________

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